

		FOR OFF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0023390</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>St Ann's Healthcare Center</u>		<p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01-01-05</u> to <u>12-31-05</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p>	
Address: <u>770 State Street</u> <u>Chester</u> <u>62233</u>			
<div>NumberCityZip Code</div>			
County: <u>Randolf</u>			
Telephone Number: <u>618-826-2314</u> Fax # <u>618-826-2316</u>			
IDPA ID Number: <u>37-1023098001</u>		<div>Officer or Administrator of Provider</div> <div>(Signed) _____ (Date) _____</div> <div>(Type or Print Name) _____</div> <div>(Title) _____</div> <div>(Signed) _____ (Date) _____</div> <div>Paid Preparer</div> <div>(Print Name and Title) <u>David Reis</u> <u>President</u></div> <div>(Firm Name & Address) <u>WDM Computer Services Inc.</u> <u>1900 Harrison St. Quincy, IL 62301</u></div> <div>(Telephone) <u>217-228-1950</u> Fax # <u>217-222-6053</u></div> <div>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</div>	
Date of Initial License for Current Owners: <u>03-01-1997</u>			
Type of Ownership:			
<div><div><input type="checkbox"/> VOLUNTARY, NON-PROFIT</div><div><input type="checkbox"/> Charitable Corp.</div><div><input type="checkbox"/> Trust</div><div>IRS Exemption Code _____</div></div> <div><input checked="" type="checkbox"/> PROPRIETARY</div> <div><input type="checkbox"/> Individual</div> <div><input type="checkbox"/> Partnership</div> <div><input type="checkbox"/> Corporation</div> <div><input checked="" type="checkbox"/> "Sub-S" Corp.</div> <div><input type="checkbox"/> Limited Liability Co.</div> <div><input type="checkbox"/> Trust</div> <div><input type="checkbox"/> Other _____</div>			

☐ GOVERNMENTAL☐ State☐ County☐ Other _____

#	0023390	Report Period Beginning:	01-01-05	Ending:	12-31-05
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D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

**E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)**

None

F. Does the facility maintain a daily midnight census? Yes

YES ☐ NO ☒

YES ☐ NO ☒

Date started 03-01-1997

YES ☐ Date _____ NO ☒

YES ☒ NO ☐ If YES, enter number

of beds certified	32	and days of care provided	2,340
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Medicare Intermediary MUTUAL OF OMAHA

ACCRUAL	<input checked="" type="checkbox"/>	MODIFIED	<input type="checkbox"/>	CASH*	<input type="checkbox"/>
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Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 2005 **Fiscal Year:**

*** All facilities other than governmental must report on the accrual basis.**

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **55.45%**

Facility Name & ID Number St Ann's Healthcare Center # 0023390 Report Period Beginning: 01-01-05 Ending: 12-31-05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	232,906	14,841	6,303	254,050		254,050		254,050			1
2	Food Purchase		121,967		121,967	(8,607)	113,360	(5,185)	108,175			2
3	Housekeeping	67,568	17,746	800	86,114		86,114		86,114			3
4	Laundry	54,357	9,967		64,324		64,324		64,324			4
5	Heat and Other Utilities			97,454	97,454		97,454		97,454			5
6	Maintenance	48,561	15,227	62,367	126,155		126,155		126,155			6
7	Other (specify):*											7
8	TOTAL General Services	403,392	179,748	166,924	750,064	(8,607)	741,457	(5,185)	736,272			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	994,539	251,888	6,644	1,253,071		1,253,071	(10,927)	1,242,144			10
10a	Therapy	28,539		316,725	345,264		345,264		345,264			10a
11	Activities	35,315	11,551	2,039	48,905		48,905		48,905			11
12	Social Services	35,818	1,920	3,575	41,313		41,313		41,313			12
13	CNA Training											13
14	Program Transportation		3,679		3,679		3,679		3,679			14
15	Other (specify):* SALES TAX			1,522	1,522		1,522	(1,522)				15
16	TOTAL Health Care and Programs	1,094,211	269,038	330,505	1,693,754		1,693,754	(12,449)	1,681,305			16
	C. General Administration											
17	Administrative	93,073			93,073		93,073		93,073			17
18	Directors Fees											18
19	Professional Services			92,363	92,363		92,363	(72,000)	20,363			19
20	Dues, Fees, Subscriptions & Promotions			39,238	39,238		39,238	(27,867)	11,371			20
21	Clerical & General Office Expenses	54,890	11,917	15,831	82,638		82,638		82,638			21
22	Employee Benefits & Payroll Taxes			227,452	227,452	8,607	236,059		236,059			22
23	Inservice Training & Education			1,368	1,368		1,368		1,368			23
24	Travel and Seminar			2,210	2,210		2,210		2,210			24
25	Other Admin. Staff Transportation		3,679		3,679		3,679		3,679			25
26	Insurance-Prop.Liab.Malpractice			77,157	77,157		77,157		77,157			26
27	Other (specify):* BAD DEBTS			68	68		68	(68)				27
28	TOTAL General Administration	147,963	15,596	455,687	619,246	8,607	627,853	(99,935)	527,918			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,645,566	464,382	953,116	3,063,064		3,063,064	(117,569)	2,945,495			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			69,902	69,902		69,902	1,966	71,868			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			84,713	84,713		84,713	(342)	84,371			32
33	Real Estate Taxes			33,028	33,028		33,028	390	33,418			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* PENALTY			803	803		803	(803)				36
37	TOTAL Ownership			188,446	188,446		188,446	1,211	189,657			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			7,705	7,705		7,705		7,705			40
41	Coffee and Gift Shops		6,854		6,854		6,854		6,854			41
42	Provider Participation Fee				65,153		65,153		65,153			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		6,854	7,705	79,712		79,712		79,712			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,645,566	471,236	1,149,267	3,331,222		3,331,222	(116,358)	3,214,864			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,185)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(10,927)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(342)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,522)	15		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(72,000)	19		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(803)	36		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(571)	20		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(68)	27		24
25	Fund Raising, Advertising and Promotional	(27,296)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule PROPERTY TAX ADJ	390	33		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (118,324)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,966		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (116,358)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Ann's Healthcare Center # 0023390 Report Period Beginning: 01-01-05 Ending: 12-31-05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,185)	0	0	0	0	0	0	0	0	0	0	(5,185)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,185)	0	0	0	0	0	0	0	0	0	0	(5,185)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(10,927)	0	0	0	0	0	0	0	0	0	0	(10,927)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(1,522)	0	0	0	0	0	0	0	0	0	0	(1,522)	15
16	TOTAL Health Care and Programs	(12,449)	0	0	0	0	0	0	0	0	0	0	(12,449)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(72,000)	0	0	0	0	0	0	0	0	0	0	(72,000)	19
20	Fees, Subscriptions & Promotions	(27,867)	0	0	0	0	0	0	0	0	0	0	(27,867)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(68)	0	0	0	0	0	0	0	0	0	0	(68)	27
28	TOTAL General Administration	(99,935)	0	0	0	0	0	0	0	0	0	0	(99,935)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(117,569)	0	0	0	0	0	0	0	0	0	0	(117,569)	29

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
BLAIN RICHARD	50	ST. ANN'S HEALYHCARE	CHESTER	RDR MGMT	HOYLETON	MGMT/LEASING
MIKE & GAIL GREER	50	ST. ANN'S HEALYHCARE	CHESTER	GREER MGMT	CARLYLE	MGMT
BLAIN RICHARD	25	CLINTON MANOR	NEW BADEN			
MIKE & GAIL GREER	25	CLINTON MANOR	NEW BADEN			
MIKE & GAIL GREER	100	OFALLON HEALTHCARE	OFALLON			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	DEPRECIATION	\$	RDR MGMT/LEASING		\$ 1,966	\$ 1,966	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 1,966	\$ * 1,966	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St Ann's Healthcare Center # 0023390 Report Period Beginning: 01-01-05 Ending: 12-31-05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BLAIN RICHARD	PRESIDENT	OFFICER	50.00	ST. ANN'S	20	50.00		\$		1
2	MIKE GREER	SECRETARY	OFFICER	50.00	ST. ANN'S	8					2
3	MIKE GREER	PRESIDENT	OFALLON	100.00		8					3
4	BLAIN RICHARD	PRESIDENT	RDR MGMT	100.00	ST. ANN'S	10		MGMT FEES	36,000	19-3	4
5	MIKE GREER	PRESIDENT	GREER MGMT	100.00	ST. ANN'S	10		MGMT FEES	36,000	19-3	5
6	MIKE GREER	GREER MGMT	OFALLON	100.00		10					6
7	MIKE GREER	GREER MGMT	CLINTON		24,000	2					7
8	BLAIN RICHARD	RDR MGMT	CLINTON		24,000	4					8
9	BLAIN RICHARD	RDR MGMT	SO ILL COMM S	20.00	18,337	4					9
10	MIKE GREER	GREER MGMT	SO ILL COMM S	20.00	18,337	1					10
11	BLAIN RICHARD	PRESIDENT	CLINTON	25.00	14,300	1					11
12	MIKE GREER	SECRETARY	CLINTON	25.00	14,300	1					12
13								TOTAL	\$ 72,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number St Ann's Healthcare Center # 0023390 Report Period Beginning: 01-01-05 Ending: 12-31-05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1					\$	\$			1
	2									2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	FIRST NATIONAL BANK		X	MORTGAGE	\$9,436.74	10-03-01	\$ 850,000	\$ 525,804	10-15-06	4.7800	\$ 25,885	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	OWNER LOANS	X		CASH FLOW		04-01-05	1,285,000	1,285,000	03-31-06	6.0000	45,998	6	
7	BUENA VISTA		X	LINE OF CREDIT		01-01-03	192,030	192,030			12,830	7	
8												8	
9	TOTAL Facility Related				\$9,436.74		\$ 2,327,030	\$ 2,002,834			\$ 84,713	9	
	B. Non-Facility Related*												
10												10	
11	INVESTMENT INTEREST		X								(342)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (342)	14	
15	TOTALS (line 9+line14)						\$ 2,327,030	\$ 2,002,834			\$ 84,371	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

3. Under or (over) accrual (line 2 minus line 1).

4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.
(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

200029,5228

200130,4719

200230,75710

200333,02811

200433,41812

* ADDED 390 FOR PRPOERTY TAX

FOR OHF USE ONLY

13FROM R. E. TAX STATEMENT FOR 2004\$13

14PLUS APPEAL COST FROM LINE 5\$14

15LESS REFUND FROM LINE 6\$15

16AMOUNT TO USE FOR RATE CALCULATION \$16

\$16,9771

\$33,4182

\$16,4413

\$16,9774

\$5

\$6

\$* 334187

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Ann's Healthcare Center COUNTY Randolph

FACILITY IDPH LICENSE NUMBER 0023390

CONTACT PERSON REGARDING THIS REPORT MIKE GREER

TELEPHONE 618-826-2314 FAX #: 618-826-5047

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 18-034-014-00	NURSING HOME	\$ 2,365.44	\$ 2,365.44
2. 18-037-005-00	NURSING HOME	\$ 95.26	\$ 95.26
3. 18-034-011-00	NURSING HOME	\$ 30,516.94	\$ 30,516.94
4. 18-034-009-00	NURSING HOME	\$ 78.74	\$ 78.74
5. 18-037-006-00	NURSING HOME	\$ 145.96	\$ 145.96
6. 18-040-003-00	NURSING HOME	\$ 216.06	\$ 216.06
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 33,418.40	\$ 33,418.40

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,246 B. General Construction Type: Exterior BRICK Frame WOOD, STEEL, CONCRETE Number of Stories 2

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY	103,500	1977	\$ 20,000	1
2					2
3	TOTALS	103,500		\$ 20,000	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	48		1977	1937	\$ 404,102	\$	20	\$	\$	\$ 404,102	4
5	46		1977	1976	250,000	7,327	33	7,327		219,469	5
6	10		1985	1985	104,150	3,171	33	3,171		65,831	6
7	15		1987	1987	344,144	10,417	33	10,417		191,360	7
8			1991	1991	357,704	11,964	30	11,964		167,281	8
	Improvement Type**										
9	BUILDING IMP			1978	500		8			500	9
10	NEW ROOF			1983	9,450		15			9,450	10
11	BUILDING IMP			1983	4,469		15			4,469	11
12	ELECTRICAL IMP			1985	3,130		15			3,130	12
13	ROOF REPAIRS			1987	1,830	92	20	92		1,661	13
14	FIRE ALARM			1987	3,900		8			3,900	14
15											15
16	NEW ROOF			1989	4,000		15			4,000	16
17	PARKING LOT			1991	7,708		10			7,708	17
18	BUILDING IMP			1992	12,806	502	20	502		9,751	18
19	TELEPHONE SYSTEM			1992	10,071		10				19
20	CUBICLE TRACK			1992	6,531		8			6,531	20
21	LAND IMP			1993	1,897	127	15	127		1,536	21
22	A/C UNIT			1984	5,625		8			5,625	22
23	BUILDING IMP			1994	45,734	1,819	20	1,819		30,426	23
24	BUILDING IMP			1993	10,012		10			10,012	24
25	PAINTING			1995	11,460		10			11,460	25
26	ROOF REPAIRS			1995	11,167	561	20	561		6,113	26
27	HANDRAILS			1995	20,700		8			20,700	27
28	BOILER			1995	21,690	1,455	15	1,455		14,779	28
29	ELECTRIAL,FIRE ALARM			1997	12,017	624	8	624		9,362	29
30	NEW ROOF			1999	30,546	1,535	20	1,535		10,107	30
31	NEW ROOF			2000	3,990	266	15	266		1,397	31
32	A/C UNIT			2000	7,265	907	8	907		5,300	32
33	FLOORING			2004	15,971	1,077	15	1,077		1,791	33
34	A/C UNIT			2004	6,378	806	8	806		1,074	34
35	SECURITY ALARM			2004	5,143	644	8	644		904	35
36	WASHER			2004	7,887	986	8	986		1,150	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,741,977	\$ 44,280		\$ 44,280	\$	\$ 1,230,879	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$194,359	\$18,924	\$20,890	\$1,966	8	\$146,256	71
72	Current Year Purchases	21,609	1,589	1,589		8	1,589	72
73	Fully Depreciated Assets	25,519				8	25,519	73
74								74
75	TOTALS	\$241,487	\$20,513	\$22,479	\$1,966		\$173,364	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	85 CHEV BUS	1996	\$6,000	\$	\$	\$	3	\$6,000	76
77	FACILITY	96 DODGE VAN	2001	4,463	1,487	1,487		3	3,347	77
78	FACILITY	VAN	2001	17,810	3,622	3,622		3	14,489	78
79										79
80	TOTALS			\$28,273	\$5,109	\$5,109	\$		\$23,836	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$2,031,737	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$69,902	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$71,868	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$1,966	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,428,079	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	ADM AUTO	\$27,739	\$	\$27,739	86
87					87
88					88
89					89
90					90
91	TOTALS	\$27,739	\$	\$27,739	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
- If NO, see instructions.
- ☐ YES
- ☒ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
- This amount was calculated by dividing the total amount to be amortized
- by the length of the lease
-
-

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
-
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$
-
- Description:
-

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	\$
13.	/2007	\$
14.	/2008	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (57,460)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (7,343))	1,181,347		3
4	Supply Inventory (priced at FIFO)	33,177		4
5	Short-Term Investments			5
6	Prepaid Insurance	29,807		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,186,871	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000		13
14	Buildings, at Historical Cost	1,680,888		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	311,811		16
17	Accumulated Depreciation (book methods)	(1,409,699)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 603,000	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,789,871	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 85,405	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	95,342		30
31	Accrued Taxes Payable (excluding real estate taxes)	(13,146)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,879		32
33	Accrued Interest Payable	38,893		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 208,373	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,285,000		39
40	Mortgage Payable	525,804		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	LINE OF CREDIT	192,030		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,002,834	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,211,207	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (421,336)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,789,871	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (127,787)	1
2	Restatements (describe):		2
3	2004 INCOME TAX ADJUSTMENTS	6,531	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (121,256)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(370,376)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) SALE OF RESIDENTIAL DIVISION	70,296	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (300,080)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (421,336)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,415,042	1
2	Discounts and Allowances for all Levels	77,448	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,492,490	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	375,270	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 375,270	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	6,533	12
13	Barber and Beauty Care	8,429	13
14	Non-Patient Meals	5,185	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	61,670	17
18	Sale of Supplies to Non-Patients	10,927	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 92,744	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	342	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 342	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,960,846	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	750,064	31
32	Health Care	1,693,754	32
33	General Administration	619,246	33
	B. Capital Expense		
34	Ownership	188,446	34
	C. Ancillary Expense		
35	Special Cost Centers	14,559	35
36	Provider Participation Fee	65,153	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,331,222	40
41	Income before Income Taxes (line 30 minus line 40)**	(370,376)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (370,376)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,088	2,104	\$ 55,820	\$ 26.53	1
2	Assistant Director of Nursing	348	348	7,083	20.35	2
3	Registered Nurses	7,636	8,172	142,482	17.44	3
4	Licensed Practical Nurses	19,586	21,266	297,151	13.97	4
5	CNAs & Orderlies	51,061	54,292	492,003	9.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,375	2,375	28,539	12.02	8
9	Activity Director	1,966	2,118	19,990	9.44	9
10	Activity Assistants	1,713	1,801	15,325	8.51	10
11	Social Service Workers	3,250	3,362	35,818	10.65	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	4,249	4,433	54,888	12.38	14
15	Cook Helpers/Assistants	22,762	23,919	178,018	7.44	15
16	Dishwashers					16
17	Maintenance Workers	4,550	4,822	48,561	10.07	17
18	Housekeepers	7,086	7,714	67,568	8.76	18
19	Laundry	6,403	6,771	54,357	8.03	19
20	Administrator	1,740	1,756	52,073	29.65	20
21	Assistant Administrator					21
22	Other Administrative	2,088	2,088	41,000	19.64	22
23	Office Manager					23
24	Clerical	4,902	5,582	54,890	9.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	143,803	152,923	\$ 1,645,566 *	\$ 10.76	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	120	\$ 6,303	1-3	35
36	Medical Director				36
37	Medical Records Consultant	48	2,800	10-3	37
38	Nurse Consultant	24	1,204	10-3	38
39	Pharmacist Consultant	96	1,460	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,039	11-3	44
45	Social Service Consultant	48	3,575	12-3	45
46	Other(specify)				46
47	Alz consultant		1,180	10-3	47
48					48
49	TOTAL (lines 35 - 48)	384	\$ 18,561		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Roger Daubach	ADM		\$ 52,073	Workers' Compensation Insurance	\$	54,826	IDPH License Fee	\$ 995
				Unemployment Compensation Insurance		27,957	Advertising: Employee Recruitment	420
				FICA Taxes		121,840	Health Care Worker Background Check	
				Employee Health Insurance		22,164	(Indicate # of checks performed 155)	2,075
				Employee Meals		8,607	Ill Sec of State	521
				Illinois Municipal Retirement Fund (IMRF)*			Div of mgmt	170
				401k plan exp		665	Advertising	27,186
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 52,073				Ill Healthcare Assoc	7,140
(List each licensed administrator separately.)							Subscriptions	731
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Bev Froeming			\$ 41,000				Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 41,000				In-State Travel	
(Attach a copy of any management service agreement)							see attached list	2,210
C. Professional Services								
Vendor/Payee	Type		Amount					
Herm Bodewes	Legal		\$ 222				Seminar Expense	
WDM Computer Inc.	Accounting/Data Proc		20,141					
Greer Mgmt	Management		36,000					
RDR Mgmt	Management		36,000					
Non Allow			(72,000)					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 20,363	TOTAL		\$	Entertainment Expense	()
(If total legal fees exceed \$2500 attach copy of invoices.)							(agree to Sch. V,	
							line 24, col. 8)	\$ 2,210

* Attach copy of IMRF notifications

**See instructions.

(See instructions.)

[illegible]

Facility Name & ID Number St Ann's Healthcare Center

0023390

Report Period Beginning:

01-01-05

Ending:

12-31-05

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Ill Healthcare 6569
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? 571
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 8YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,333 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,153
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 8,607 Has any meal income been offset against related costs? YES Indicate the amount. \$ 5,185
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 50
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? N
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? N
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.